CORPORATE BACKGROUND AND EXPERIENCE

Please provide the information requested below about your organization.

1. **Corporate Information**
   - Volunteer State Health Plan, Inc. (VSHP)
   - 801 Pine Street, Chattanooga, TN 37402
   - 423-535-7767 (Phone)
   - 423-535-7601 (Fax)
   - Sonya_Nelson@bcbst.com

2. **If a subsidiary or affiliate of a parent organization, corporate information of parent organization**
   - BlueCross BlueShield of Tennessee
   - 801 Pine Street, Chattanooga, TN 37402
   - 423-535-5815 (Phone)
   - 423-535-6300 (Fax)
   - Ron_Harr@bcbst.com

3. **State of incorporation or where otherwise organized to do business**
   Tennessee

4. **States where currently licensed to accept risk and a description of each license**

   VSHP is licensed in Tennessee as a Health Maintenance Organization pursuant to Tenn. Code Ann. Section 56-32-101, *et. seq.* with full authorization, including the acceptance of risk, as provided for in that chapter.

5. **Contact Information**
   - Sonya Nelson
   - VP Government Medicaid Administration
   - 423-535-7767 (Phone)
   - 423-535-7601 (Fax)
   - Sonya_Nelson@bcbst.com

6. **Program Experience - General**
   Given TennCare's history with small, inexperienced plans becoming insolvent, the State is interested in contracting with MCOs that have substantial experience with capitation, particularly for the Medicaid population. Tennessee also intends to require that all MCOs be NCQA-accredited or receive NCQA-accreditation for the Medicaid product within a specified time period after contract award.

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

Yes, VSHP has administered Medicaid benefits for the State of Tennessee since 1994 when the TennCare program was implemented. We have operated under several different capitation arrangements, as well as under administrative services only arrangements. Listed below are the specific arrangements we have administered for TennCare:

BlueCare Arrangements	Effective Dates
Full Risk	1/1/1994 - 6/30/2000
Exigency (ASC Agreement)	7/1/2000 - 6/30/2001
Risk w/$33 million loss limit	7/1/2001 - 6/30/2002
Stabilization	7/1/2002 - 6/30/2005
Pay-for-Performance	7/1/2005 - Current

b) Are you currently accredited by NCQA for your Medicaid product line?

Volunteer State Health Plan has taken the appropriate steps to begin the certification process for NCQA. Currently, the application for the VSHP NCQA accreditation is in process, and the survey has been scheduled for November 6th and 7th 2006.

If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award?

Our parent company, BlueCross BlueShield of Tennessee, had NCQA accreditation experience with both Commercial and Medicare HMOs prior to making business decisions to dissolve these business entities. In addition, the essential health plan functions of Credentialing, Utilization Review, Case Management, HIPAA Compliance Program, and web site programs have obtained and maintained URAC accreditation.

Do you have experience with HEDIS and CAHPS? Please explain.

BlueCross BlueShield of Tennessee has approximately 10 years experience with producing HEDIS and CAHPS measures for its TennCare, commercial HMO, and Medicare HMO products. The HEDIS, CAHPS, and Quality Improvement Activity data are utilized as part of the overall corporate Quality Improvement

Plan to support the health status of members and improve service to members and providers.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

Volunteer State Health Plan is currently the largest managed care organization administering TennCare services in the state of Tennessee.

7. **Medicaid Program Experience - Services**

Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

VSHP currently contracts for Medicaid sources in Tennessee. The specific services include:

Service	Does VSHP Provide Service?	Is Service Provided Directly or Subcontracted?
Physical Health Benefits	Yes	Directly
Dental Benefits	No	Benefit Carved Out
Vision Benefits	Yes	Directly
Non-Emergency Transportation	Yes	Directly
Behavioral Health Benefits	No	Benefit Carved Out
Pharmacy Benefits	No	Benefit Carved Out
Long-Term Care Benefits (nursing facility and home and community based waiver services)	No	Benefit Carved Out
Home Health	Yes	Directly
Claims Processing and Adjudication	Yes	Directly
Quality Assurance	Yes	Directly
Utilization Management	Yes	Directly
Case Management	Yes	Directly
Disease Management	Yes	Directly
Provider Credentialing	Yes	Directly
Enrollment Assistance	Yes	Directly
Member Services (inquiry, id cards	Yes	Directly

Member Grievances/Appeals	Yes	Directly

8. **Medicaid Program Experience - Population**
Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

- Aged, Blind and Disabled – excluding dual eligibles
- Dual Eligibles: individuals eligible for both Medicaid and Medicare
- TANF and TANF-Related
- SCHIP
- Waiver Expansion Population (low-income uninsured)
- SPMI (Seriously and Persistently Mentally Ill)
- SED (Seriously Emotionally Disturbed Children/Youth)

VSHP currently administers Medicaid services in Tennessee. As an MCO for TennCare, we do not determine or maintain the member eligibility, and do not receive the eligibility classifications in the above descriptions. Therefore, we have charted the eligibility based on the classifications we receive from the Bureau of TennCare.

VSHP Membership as of November 9, 2005 (run date 11/14/05) Tennessee Eligibility Description	Member Count
Dual Medicare/Medicaid	120,030
Medically Eligible	25,223
Uninsured	9,348
Disabled	100,883
Medicaid	404,514
Dual Medicare/TennCare	2,806
TOTAL	662,804

9. **Medicaid Program Experience – Payment Methodology**
Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

State	D/b/a	Type of Risk	Description
Tennessee	BlueCare	Shared Risk	This risk contract provides for a potential upside bonus equal to 15% of the administrative dollars received, and a potential downside risk equal to 10% of the administrative dollars received.
Tennessee	TennCare*Select*	Administrative Services Only	This contract contains no risk.

10. **Experience – Former Medicaid and/or Commercial**

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

Not Applicable – we currently contract to provide Medicaid services

11. **Reformed Managed Care Model**

As part of its reform efforts, the State of Tennessee intends to return to a capitated managed care delivery system. The State is interested in contracting with experienced plans that are capable of coordinating services across the full continuum of care – from preventive and primary care services to long-term care services, as well as across physical and behavioral health conditions. The MCO benefit package will include behavioral health services, but long-term care services and pharmacy services will continue to be carved-out. As part of this emphasis on management and coordination of care the State intends to include a strengthened disease management strategy designed to manage high cost conditions and to manage care across the continuum of service.

A. **Behavioral Health**

Unlike the current program, the State intends to coordinate behavioral and physical health services through the MCO relationship in order to improve coordination of care. This decision results from (a) the State's previous experience with disputes between the MCO and BHO regarding the responsibilities of each entity for particular patients or diagnoses and (b) the high proportion of behavioral health products and services provided by general and family practitioners and pediatricians, currently beyond the reach of the BHO's expertise. The State also seeks to expand its options relative to the likely bidding pool in order to ensure participation of the broadest array of experienced

candidates. Thus, both single-entity, "pure-play" BHOs and MCOs, as well as integrated health plans may participate; however, the MCO would be expected to be the primary contractor and to fully manage and coordinate an enrollee's physical health and behavioral health conditions.

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

Behavioral health services are carved out for the current TennCare contract. However, VSHP is partnering with Magellan Health for behavioral health services in the Middle Grand Region.

2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

Our Model for medical and behavioral care coordination includes quarterly meetings focusing on activities to improve coordination between our case management functions and provider focused activities. These activities include approving Clinical Practice Guidelines for Behavioral Health Disorders for website dissemination to PCPs, writing co-existing disorders protocols for medical and behavioral health care, sponsoring evidence-based Behavioral/Physical Health training, coordinating behavioral health support with PCPs and psychiatric providers, and referral to behavioral health providers for medication evaluation and psychotherapeutic services.

We have implemented several initiatives that address the racial, cultural and ethnic needs of our members, including: regional trainings with providers using specific modules about cultural sensitivity and effectiveness, cultural sensitivity in-service trainings for Care Management staff, and ensuring that interpreter and translation services are available to members who are not comfortable speaking English.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with

SED and SPMI.

a. Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).

We have developed diverse strategies for managing and coordinating care for individuals with SPMI/SED. We have partnered with community providers across Tennessee to develop multi-agency planning initiatives that foster principles of recovery and resiliency. Examples include PACT (Program for Assertive Community Treatment), CTT (continuous treatment team), CCFT (comprehensive children and family treatment), and SMISA (seriously mentally ill substance abuse) programs. We have also implemented a number of psychiatric rehabilitation programs in different regions of Tennessee.

b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?

We recommend that the contractual design or structure in Middle Tennessee ensure that the new program specifically addresses the needs of people with SPMI/SED, and that they are effectively identified in the system. Mechanisms for achievement include an enhanced benefit structure for those identified as SPMI/SED (similar to the benefit plan currently in place). The plan should also demonstrate concrete expertise in identifying and managing this population.

c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?

No, excluding people with SPMI/SED from the covered population would not impact our decision to bid.

d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?

No, VSHP's response would not change.

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.

VSHP has over 10 years experience working closely with Community Mental Health Centers (CMHAs) across Tennessee, partnering with all key community

providers in the State. We recognize the critical role played by CMHAs as the traditional anchor providers for people with serious mental illness in Tennessee, as well as other recipients of public sector behavioral health services. We have worked collaboratively with these community providers to implement initiatives that improve outcomes for TennCare enrollees. In order to expand the available service continuum for members, we have conducted ongoing service gap analyses, and partnered with local providers to develop and implement expanded services needed in each region. VSHP has also participated in quarterly regional quality meetings featuring provider training, data presentation, and feedback from the BHO and providers. Further, we have played a leadership role in the development of a SSOC (supervised system of care) that features oversight and comprehensive audits of community-based providers.

5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?

   No recommendations.

B. **Pharmacy Services**

Pharmacy has been a key driver of expenditure growth in the TennCare program. In an effort to control pharmacy costs, the State carved-out pharmacy and contracted with a pharmacy benefits manager (PBM). The State intends to continue the current PBM contract and the carve-out of pharmacy services. The MCO, in conjunction with the PBM, will support all efforts to manage the pharmacy benefit, including, but not limited to, provider education; identification and monitoring of outlier prescribers and users; and coordination of prescriptions across providers.

1. In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.

   Access should be timely, accurate, current, and comprehensive. The pharmacy claims activity is essential for the successful operation of the TennCare program that includes "real time" or next day pharmacy data on prescription renewals or lack of renewals.

C. **Long-Term Care Services**

Long-term care services (nursing facility and services through home and community based waivers) will be carved-out of the MCO benefit package. However, individuals receiving long-term care services (including the aged, blind and disabled population) will be enrolled in MCOs for their acute and behavioral health services.

1. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

   For situations where community based services are a more cost effective alternative, our recommendation is that the State assign a specific dollar amount as a performance incentive for MCOs who successfully increase utilization of home and community based services, while decreasing reliance on institutional care.

   An effective program for coordination of acute and long term care services will require the collaboration of the TennCare Bureau, other state agencies involved in long term care, and medical and behavioral network providers.

F. **Disease Management**

Physical Health

The State intends to incorporate the principles of disease management into its reformed managed care program and a comprehensive and coordinated approach will be expected of all participating MCOs. At a minimum the expectation would be that the MCO apply disease management techniques to the following physical health conditions:

- Diabetes mellitus
- Congestive heart failure
- Coronary artery disease
- Asthma
- Chronic-obstructive pulmonary disease
- High-risk obstetrics

1. Do you have a formal disease management program?

Yes, the current VSHP Disease Management programs were designed in accordance with National Committee for Quality Assurance (NCQA) standards and guidelines.

If yes, where is it currently being used, e.g., which State Medicaid programs?

VSHP currently has disease management programs in place for both of our Medicaid products - BlueCare and TennCare*Select.* In addition, behavioral health DM services are provided.

Again, if yes, on which conditions does your program focus today?

Our current programs include: Diabetes Mellitus, Congestive Heart Failure, High-risk Obstetrics, and Coronary Artery Disease: Acute Myocardial Infarction/Beta-blocker, and a comprehensive Obesity Disease Management Program. VSHP plans to expand Coronary Artery Disease and rollout Asthma and Chronic-Obstructive Pulmonary

Disease programs in 2006.

2. Is the function fully performed within your organization or do you subcontract with another entity?

VSHP disease management programs are fully functional within the organization. VSHP customized in-house programs using our vast experience in managing the unique characteristics associated with all eligibility categories within the Medicaid population. Our experience includes enrolling more than 50% of the TennCare beneficiaries, 21% of which had Medicare dual eligibility. This population requires an intense level of services, in the community presence, and collaboration with provider and social service infrastructure. Our processes must be creative and proactive due to the transient nature of the population, lower levels of telephone service, and literacy and language barriers.

If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

Not applicable.

3. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

   Under our current arrangement, behavioral health benefits are carved out of the program. However, we have a long-standing relationship with Magellan Health Services who currently provides behavioral health disease management services to three million members in a number of states. Conditions include:

   - Depression
   - Anxiety with Mood Disorder
   - Bipolar
   - Substance Abuse – Alcohol
   - Eating Disorders

4. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity?

As stated above, VSHP has a long-standing relationship with a behavioral health organization that handles behavioral health care management.

If a subcontract arrangement is used, please fully describe such arrangements and how

coordination across entities is ensured.

Currently, behavioral health benefits are carved out of the program. However, we recognize the importance in coordination between the medical health services and the behavioral health services, and have established procedures to ensure this coordination. The Medical-Behavioral Coordination Committee manages coordination across the medical and behavioral entities, and has been in effect for many years. VSHP has protocols for complicated mixed cases, such as autism and brain injury, and developed workflows for efficient referral of cases. We produce training videos that are used by both the BHO and VSHP to further enhance coordination of care. VSHP has the ability to track and analyze referral patterns. The committee's responsibility is to identify and resolve instances where patients' treatment requires both medical and behavioral health involvement. These protocols enhance the integration of services to allow for immediate dialog between medical and behavioral care managers to respond to urgent member needs.

5. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

VSHP has over ten years experience managing the care of persons with behavioral health conditions, including depression, anxiety with mood disorder, bipolar disorder, substance abuse and schizophrenia in Tennessee. In the TennCare Program, there is currently a limited substance abuse/detoxification benefit for adults. Our clinical approach protects and conserves the member's benefit by authorizing appropriate care that is most likely to help the member. If and when benefits are exhausted, careful referrals are made to other community resources in an effort to provide continuity of care.

Overview of Care Management Process for Behavioral Health Diagnoses

Care Management in behavioral health focuses on individual needs and considers diagnosis, clinical course, social supports, and recidivism. Currently, the needs of persons with SPMI/SED are managed primarily through focused clinical programs such as intensive care management (ICM) that provides a high level of clinical oversight and aftercare for members with complex needs. The care managers identify members who may benefit from ICM based on medical/psychiatric co-morbidity, pattern and frequency of readmissions, adherence, safety, and suicidal factors. All behavioral health care managers are at a minimum a master's prepared licensed clinician and/or a licensed RN with a minimum of three years post licensure experience. Clinical backgrounds are

diverse including substance abuse, dual diagnosis, and children/youth issues.

Clinical Practice Guidelines

VSHP has a robust process of reviewing and utilizing Clinical Practice Guidelines. Currently Guidelines have been adopted for Schizophrenia, Suicide, Substance Use Disorders, Major Depression, Panic Disorder, Bipolar disorder, and Obesity. Disease specific clinical practice guidelines are utilized in Tennessee for schizophrenia, major depression, and co-occurring disorders. Provider documentation audits measure guideline compliance.

In addition, we have developed clearly defined clinical/utilization management guidelines for each level of care in the TennCare Program. These guidelines are distributed to providers in hard copy and are available on our website. VSHP provides regular feedback to providers, including their adherence to established clinical guidelines. Feedback is given through customized performance scorecards that reflect a provider's utilization trends over a specific timeframe. Protocols are in place to work with individual outlier providers in order to prevent over/under-utilization and correct quality of care issues.

G. **Capitation Model**

Under the TennCare reformed managed care model the State will be returning to capitated managed care.

1. Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.

VSHP, one of the largest Medicaid HMOs in the country, has over ten years experience in managing the delivery and financing of health care to Medicaid enrollees. We have successfully managed a number of reimbursement methodologies that include full-risk, fully capitated arrangements, and administrative services only. This also includes gain sharing and pay-for-performance arrangements, as well as a set dollar risk limit (e.g. $33 Million).

Our concern is to ensure the viability and longevity of the program and its participants. As such, our recommendations are to ensure that:

- Methodologies used to establish the capitated rates are actuarially sound,
- Changes in membership are appropriately accounted for,
- Changes in provider reimbursement are properly included,
- Mid-year benefit changes are not permitted
- Directives and ALJ rulings are consistent with the contract or reimbursed for separately, and
- Most importantly, the infrastructure of a managed care model is maintained.

2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.

Several historical factors in TennCare make it difficult for private companies to be comfortable with full risk for medical consumption. These factors include the history of benefit expansion by court actions and legislative pressure. Also, the program has been through major changes with some major categories of services (pharmacy, behavioral) being moved in and out making it difficult to produce exact data, therefore hampering actuarially sound projects. For all these reasons, we prefer a contract that includes some form of risk mitigation. We are open to proposals such as risk adjusted capitation rates, "stop loss" proposals or other models currently being used in other states to limit an MCO's risk in serving this unique population.

Outstanding Court Rulings (Negative)

The Bureau of TennCare needs to provide to potential bidders, in writing, the results of the court rulings and specific relief indications for the Grier Consent Decree. In addition, the bidder needs the specific requirements to administer home health benefits to be in compliance with the Newberry ruling. Both the Grier relief specifics and the requirements to properly administer Newberry are unclear today.

These outstanding issues need to be resolved prior to the release of the Request for Proposal (RFP) in order to accurately assess the "full-risk" environment.

3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:

   a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)

      VSHP's first preference is described in the response for 3.d. Our second preference would be a specific stop loss arrangement whereby dollars in excess of $X per member per year are reimbursed by the state.

   b. If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)

      VSHP is willing to administer soft benefits, however, due to the unpredictability and no clear understanding of how soft limits will be administered; we are opposed to taking risk for soft benefits.

   c. If the State adopted "soft" benefit limits, aggregate risk sharing (e.g., the

state reimburses X% of costs in excess of X% of capitation payments)

This option is VSHP's third preference. As to "soft" benefit limits, see our response to (b.) Capitation rates must be actuarially sound and reflective of the expected experience of this book of business.

VSHP would support the creation of a risk-sharing model. For example, a corridor could be established between 90% and 105% of a claim target, with the capitated health plan taking full risk for any amounts within the corridor and the State sharing 75% to 85% of the amounts beyond the ends of the corridor. Capitation rate classes should vary by age, sex and eligibility class.

Payments for pregnancies should include a delivery "kick" payment as was done in Georgia. This minimizes the risk associated with pregnant women joining an MCO in the last month or 2 months of a pregnancy.

Multiple classes of capitation rates are needed in order to effectively quantify the risk associated with anti-selection.

Actuarial sound capitation rate classes should also be available for high cost and chronic diseases. This has the added benefit of helping to mitigate the MCOs' ability to select members by developing networks that are inadequate for high cost and chronic condition members, thereby discouraging high cost members from joining the health plan. Examples of high cost and chronic diseases are:

- Asthma
- Diabetes
- HIV/AIDS
- Low Birth weight
- Transplants (unless carved out)
- Cancer
- Hemophilia
- Delivery "kick" payment
- ESRD

Carve-outs

VSHP is supportive of the State carving out certain benefits such as dental, pharmacy, and long-term care. The state should also consider carving out transplant costs, as well as the Aged, Blind, and Disabled population.

Retroactivity

As with any risk arrangement, retroactive enrollments and disenrollments must be minimized. VSHP understands it may take 1 – 3 months for Medicaid eligibility to be verified, but any retroactivity eliminates a

MCOs ability to manage care and to manage costs. MCOs do not want to recover claims payments from providers, who have, in good faith, treated Medicaid members.

Lock-in
Initially, and annually thereafter, members would have 30 days to choose an MCO, and another 30 days to change MCOs. During the remainder of the year, members would only be able to change MCOs due to a severe hardship.

d. Other

VSHP's first preference is to structure the reimbursement similar to Medicare Advantage where capitation rates are risk adjusted for each member based on their medical history.

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

Yes. Experience has taught us that there is a minimum threshold for a program to be viable (to take advantage of economies of scale, etc.). While there is no exact target, we would prefer not to serve fewer than about 50,000 lives through this contract. Conversely, given the increasing risk, we would prefer not to serve more than about 200,000 lives through this contract. (These totals would not include lives we serve through other contracts in this program.)

H. Data and Systems Capability

Critical to the success of the program is the availability of robust, timely data, including encounter data, for use by the State and MCOs to manage and monitor the program. The State is very interested in MCO capacity to obtain and provide data and reports to the State, and capacity to use data for ongoing program monitoring and quality assurance.

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

VSHP currently does Medicaid business only in the state of Tennessee. VSHP obtains, maintains, submits and uses diverse types of data. This data is obtained through multiple sources, including providers, members, the Bureau of TennCare, and other State agencies, such as DCS. We capture and maintain the data in an extensive data repository, which is used to submit the data to the Bureau of TennCare, as well as to produce various reports used by both internal and external

sources to aid in the monitoring of our performance. VSHP has the capability to submit data and produce reports using national standard formats or State specified formats. Listed below is a summary of the types of data we maintain, as well as provide to the State.

- Encounter and Claims File:
  VSHP provides to the Bureau of TennCare a weekly encounter and claims file in the ANSI X12 837 format. The file contains detailed claims information for all processed claims that are paid, denied and adjusted. The file also contains member and provider information.
- Eligibility File:
  VSHP provides to the Bureau of TennCare a daily eligibility file in the ANSI X12 834format. This file contains address, PCP, Date of Death, Date of Birth and Sex changes associated with a member.

- Provider enrollment File:
  VSHP provides to the Bureau of TennCare a monthly provider file in a state requested format. This file contains in-plan, out-of-plan, and network information for all providers.

VSHP uses the data maintained in our systems and data repository to produce an extensive array of reporting deliverables each month – including contractual reports and considerable On-Request Reports.

As a result, Volunteer State Health Plan maintains a staff of highly qualified, professional analysts, project managers, and programmers to provide dedicated, 24/7 analytical and knowledge support to the Bureau of TennCare. VSHP's analytical staff understands TennCare and has the expertise to develop both contractually required and ad hoc reporting quickly and efficiently while maintaining the highest quality standards.

Listed below are types of reports, as well as some specific examples of reports produced by VSHP for the Bureau of TennCare.

Eligibility / Premium – VSHP provides to the Bureau of TennCare on a quarterly basis, a reconciliation report in a state requested format detailing discrepancies between the premium records and the eligibility records received from the State. In addition to the quarterly report, a daily eligibility review is performed to ensure that all necessary data are present and valid. An exception report is sent to the Bureau for records with incomplete or erroneous data.

We have developed special processes so we can handle eligibility on particular categories of members such as children who enter State custody, for pregnant women, and women diagnosed with cervical and breast cancer.

Other reports in this category include:

- Enrollee Other Insurance
- Enrollee Information
- Immediate Eligibility Termination Report
- Enrollee Cost Sharing Liabilities
- DCS Enrollment Report
- Children in State Custody Reconciliation with Enrollee and Admin Fee
- Monthly DCS Invoice
- Deceased Enrollee Reconciliation
- Quarterly Enrollment Report

Cost and Utilization - A variety of cost and utilization reports are produced and provided to the Bureau of TennCare on a regular basis. The intent of these reports is to assist in monitoring and evaluating the program. Examples of the reports are:

- Top 25 Providers – by the number of services and amount paid
- Top 25 Inpatient Diagnosis – by the number of services and amount paid
- Top 25 Outpatient Diagnosis - by the number of services and amount paid
- Top 10 Inpatient Surgery/Maternity Procedures - by the number of services and amount paid
- Top 10 Outpatient Surgery/Maternity Procedures - by the number of services and amount paid
- High Cost Claimant – Members who have exceeded a set payment threshold
- Cost and Utilization Summary Information – data by provider specialty, member eligibility category, type of service, etc.

Network adequacy or performance -Throughout the year VSHP completes multiple reviews of our provider network using GeoAccess software and other internal tools to determine if our network has adequate practitioners and organizational providers to provide Primary Care, Facility and other specialty services within 20 miles/30 minutes for urban areas and 30 miles/30 minutes for rural areas. We also evaluate access and availability of our specialty services through review of the number of specialists available versus member ratios in specific geographic areas. In addition, we have ongoing monitoring of our networks by our Provider Relations Representatives.

Other reports required by the State include:

Provider

- Provider Termination Letters
- Provider Network Enrollment
- Single Case Agreement Report
- Quarterly BlueCare and TennCare*Select* Provider Profile Analysis (PPA)
- Federally Qualified Health Centers (FQHC) Report

- Essential Hospital Services
- Non-discrimination Compliance - List by CSA of Providers by Ethnic Origin
- Provider Reimbursement – Providers and subcontractors Contracted during the preceding calendar quarter
- Referrals and Exemptions
- Conflict of Interest
- List of Credentialed BPN-PCPs to BHO with Proof of Compliance to TennCare
- PCP Profiling Activity Report
- Related Providers and Subcontractors and Explanation of Payments
- Out of Network Utilization
- Specialist Referrals
- BPN-PCP Notification of DCS Liaison Changes

Medical Management

- Private Duty Nursing Report
- Home Health Care Request Monitoring Report
- TENNderCARE Quarterly Report
- TENNderCARE Annual Report
- Prior Authorizations Report
- 2005 Quality Improvement Program Description
- 2005 Quality Improvement Workplan
- Performance Indicators
- Annual Study on Pregnancy
- Annual Study on Immunizations
- EPSDT Adolescent Well Visit Study – Collaborative Focus Study
- Breast Cancer Study
- Cervical Cancer Screening QIA
- Lead Screening Clinical QIA
- Beta Blocker Clinical QIA
- Diabetes Eye Exam Clinical QIA
- EPSDT Collaborative Study Service QIA
- MAC Unit Service QIA
- Quality Improvement Activity Update Grid including PC assignments and Prior Authorization Reports
- Monthly Home Health Monitoring Reports
- Monthly Prior Authorization Report/UM Certification Report
- Provider Network Adequacy and Benefit Delivery Review
- HEDIS/Compliance (BAT Analysis)
- HSAG Quality Review
- Specialty Physician Services Chart
- PCP Assignment Report
- Continuity of Care Report
- UM Program Description Annual Evaluation and Workplan

- CAHPS Survey Reporting
- Provider Office Staff Satisfaction with Prior Authorization Process
- Provider Satisfaction Survey Reporting
- Pharmacy Generic Use Reports
- Emergency Rooms Utilization

Financial

- Medical Services Monitoring Report
- Medical Fund Target
- Invoice File
- Quarterly Financial Report
- Financial Plan and Projection of Operating Results
- Provider Payment Process Reconciliation
- Actuarial OCL Certification
- NAIC Annual Statement
- Audited Financial Statements
- CPA Audit Report
- Financial Forecast
- Premium Tax Filing
- Aggregate Capitation
- Subrogation Recoveries
- Performance Indicator Results
- 1099 Reports
- Reconcile NAIC to Medical Services Monitoring Report
- Quarterly TPL Recovery Data

Quality

- Call Abandonment Rate and Call Answer Timeliness for UM
- Telephone Activity Report
- Inquiry accuracy and timeliness
- Claims Lag Table
- Quarterly prompt pay analysis
- Claims and Telephone Performance Results & Claim Payment Accuracy Audit

Behavioral Health

- CRG/TPG rating scores used to assign member SPMI/SED status.
- Provider Payment Process Reconciliation
- Aggregate Capitation

Other

- Ownership and Controlling Interest Disclosure
- Non-discrimination Compliance – Complaints/Appeals filed in which discrimination is alleged

- Internal Audit Plan
- Corporation Annual Report
- Holding Company Registration Summary
- HRBC Report
- Management Discussion and Analysis
- Title VI –Employee Discrimination Complaints
- Title VI –Personnel Discrimination Policies
- Title VI –Supervisory Personnel by Race and Sex
- Title VI –Providers by Race
- Title VI –Translation/Interpreter services by requesting enrollees
- Title VI-Policy that demonstrates non-discrimination in provision of services with Limited English Proficiency along with listing of translator/interpreter services utilized by Contractor
- Title VI Compliance Plan and Assurance of Non-Discrimination
- Monthly Third Party Resources

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

As described in the response for Question #1, VSHP obtains and maintains extensive data, including encounter and claims, eligibility, medical management, and provider data. The data is maintained in an extensive data repository, and used with various software packages to perform analysis, research, and development of programs for the BlueCare and TennCare*Select* population. These packages are used for general analysis; analytical projects; and for Case and Disease Management.

One of the packages available is very sophisticated software that is excellent for data handling and statistical analysis. The package allows for cleaning up and rearranging data in order to facilitate analysis and research. Projects that require new definitions or splitting data in unusual manners are best performed using this software package.

We utilize a different package for most research projects involving BlueCare and TennCare*Select*. This software creates a data warehouse of claims, membership, and provider data and adds some functionality to the data in the form of the DCG grouper, ETG grouper and a consistent DRG grouper. The software also combines claims related to an inpatient admission into stays to facilitate identification of the services and costs related to that admission. Many metrics that are commonly used are pre-defined in the software, which reduces the processing time of data queries.

A final tool utilized is predictive modeling software that produces predictions of both the risk level of individual members and their expected future costs. This software is used both to identify individuals who should be placed into case management and to triage members into the appropriate level of care coordination. The software also produces some additional reports that can be used by care coordinators for improving the care of

members.

One of the important features of this portion of the software identifies all the instances where members have not complied with treatment guidelines and thus have potential for care improvement. Similarly, the software produces an impact index that helps case managers prioritize their work so that they can be more efficient. All of this software allows BlueCare to answer important questions relating to the care of TennCare members. It allows for the identification of members who require intervention and parts of the health care delivery system that could be improved. The end result is better more productive care for BlueCare members.

I. **Net Worth and Restricted Deposit Requirements**

In addition to the statutory net worth and restricted deposit requirements for HMOs, TennCare MCOs must comply with contractual net worth and restricted deposit requirements. The statutory net worth requirement is made on an annual basis based on historical data (see TCA, Section 56-32-212). The MCO contract requires that the minimum statutory net worth requirement be recalculated before a significant enrollment expansion occurs. In terms of reserves, statutorily MCOs must maintain a restricted deposit in the amount of $900,000 plus specified amounts of premium revenue in excess of $20 million (see TCA, Section 56-32-212). The MCO contract requires MCOs to maintain a restricted deposit equal to the statutory net worth requirement. This requirement will be revised to clarify that the increased restricted deposit amount shall be calculated based on the MCO's TennCare revenue, unless that amount is less than the restricted deposit required by statute. If the amount calculated using only TennCare revenue is less than the restricted deposit amount required by statute, then the contractually required amount shall be equal to the restricted deposit required by statute.

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

VSHP does not anticipate that the net worth and depositing requirements will be a deterrent. VSHP has sufficiently met net worth and depository requirements in previous risk arrangements.

J. **Implementation Timeframe**

The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

The proposed timeframe is acceptable.

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?

If the release of the RFP in January should be delayed, VSHP recommends that the state adjust the procurement implementation timeframe accordingly. For example, an RFP released in February or early March would, in our opinion, offset the current scheduled start date of the contract.

Questions for RFI 318.65-217

1. Will the State release in writing the list of changes being reviewed by CMS for approval of relief from the Grier consent decree?

2. During the December 1, 2005 RFI pre-proposal meeting, the State indicated that there was relief granted from the Grier consent decree and Newberry court ruling. Can the State please provide in writing how defining medical necessity for authorizing services and the burden of proof for appeals has changed?

3. There are additional consent decrees and rulings in place that need specific clarification and requirements for administration to insure proper compliance, including John B. and Newberry.

4. Will the State provide to potential bidders, prior to the release of the RFP, the specific written requirements for these court orders?

5. Will the State provide potential bidders clarification of the definition of Private Duty Nursing and other home health services? Do they use the CMS definition? If so, what impact will the Newberry ruling have in managing the Home Health component?

6. How will Private Duty Nursing be provided in the Long Term Care environment in terms of cost-effectiveness?

7. Will the State consider carving out private duty nursing?

8. Will the State consider a carve-out for the Aged, Blind, and Disabled population?

9. Will the State provide kick payments for maternity cases?

10. Has the State considered implementing a special needs plan for dual-eligibles?

11. The State intends to continue the current PBM contract and the carve-out of pharmacy service. The RFI is requesting that the MCO support all efforts in managing the pharmacy benefit to include provider education and coordination of prescriptions across providers:

12. How will the State provide accurate and timely pharmacy data to the MCO's? Will this data be available in a "real time" mode electronically or in hard copy format?

13. How will the State measure the MCO efforts in assisting the PBM in managing the pharmacy benefit? Will the MCO share revenue in any cost savings due to

these efforts?

14. Will the State follow the current contracting guidelines provided by CMS? Will you set aside money to provide to the MCOs when it requests changes to the contract during the contract periods? (Change Orders)

15. How will the State handle retroactive eligibility additions or terminations?

16. Can the State guarantee a member lock-in to the MCO for a particular period of time? Will the State ensure that any changes during a lock-in period are for hardship reasons only?

17. When can potential bidders obtain cost and utilization data for BHO services?

18. How many MCOs will be awarded contracts in the new Middle TN Grand Region?

19. If the State does not release the RFP as scheduled in January, will they postpone the April selection date and the October effective dates?

20. What measures will the State take to prevent adverse selection of members for MCOs?

21. Is the state considering an acuity/risk adjustment model for rating, i.e. specific cap rates for asthmatics, HIV, breast cancer, cervical cancer, transplant patients, ESRD, diabetics, low birth weight infants, etc. Will any of these services be carved out?

22. What experience data will the state be publishing along with the RFP?

23. Does the state anticipate publishing a Medicaid physician fee schedule?

24. Will MCOs be allowed to offer capitation contracts to providers?

25. Will the State be developing “report cards” or quality indicator reports for participating for participating MCO’s?

26. How will the State auto-assign members to the MCO’s?

27. Will the State consider future auto-assignment on quality performance of the MCO’s?

28. Will there be minimum provider network adequacy standards for all participating MCO’s in the new Middle Tennessee Grand Region?

29. If minimum provider network adequacy standards are not met in some counties, will the MCO be excluded from required participation in that county?

30. If certain counties are excluded because of inadequate provider networks, will the State default to the back-up plan, TennCareSelect?